Rheumors
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POINTS ON JOINTS

The . . thigh . . bone . . connected . . to . . the . . shin . . bone . .

Not all joint region pain is due to arthritis. Several future Points on Joints sections will be devoted to soft tissue (non-joint related) pain. This article will address the knee.

ANSERINE BURSITIS: (Latin for goosefoot bursitis) is seen predominately in overweight, middle-aged or elderly women with big legs and osteoarthritis of the knees. Inflammation of the anserine bursa (Latin for sac) produces pain over the inner aspect of the knee about two inches below the joint. Treatment includes rest, corticosteroid injections into the bursa, exercise and weight reduction.

PREPATELLAR BURSITIS: This is manifested by swelling over the kneecap and may result from trauma or infection. Frequent kneeling, such as in scrubbing floors, may lead to prepatellar bursitis lending to the name "housemaid's knee". Treatment may include aspiration of the bursae, anti-inflammatory drugs, heat, rest, and injection of steroids. Infection should be treated with an appropriate antibiotic.

MEDIAL PLICA SYNDROME: A plica is a normal synovial fold (a folding of the inner lining of the joint) of the knee joint and can be seen under and above the kneecap, and on the medial (inner) aspect of the knee. The inner plica is especially liable to cause pain. The diagnosis must be suspected when other causes of knee pain are excluded. Diagnosis is confirmed by knee arthroscopy.

PATELLOFEMORAL PAIN SYNDROME: This syndrome consists of pain, a grinding sensation in the region of the kneecap, and stiffness occurring after prolonged sitting. Symptoms are alleviated by activity. Overactivity such as excessive stairclimbing aggravates the pain. Pain is produced when the patella is compressed against the knee joint. Another term for this disorder is chondromalacia patella. Treatment includes anti-inflammatory drugs, ice, rest, isometric exercises and, in some patients, arthroscopy.

POPLITEAL CYSTS: Also known as Baker's cysts, they are swollen bursae that may dissect or rupture causing pain in the back of the knee and into the calf. Popliteal cysts may mimic thrombophlebitis (inflammation of the veins). The cysts are most commonly seen secondary to rheumatoid arthritis, osteoarthritis, or internal derangements of the knee.

FATPAD SYNDROME: This can result in pain in the region below the kneecap and may be caused by a direct blow to this area's fatpad. The swollen fatpad may then be caught between portions of the knee during flexion and extension. Treatment includes rest and anti-inflammatory drugs such as Ibuprofen.

POPLITEAL TENDINITIS: Pain in the back of the knee may occur secondary to a tendinitis of the popliteal tendons (the hamstrings and popliteus). There is tenderness on examination and straight leg raising causes pain. The motion of running down hill increases the strain on this group of tendons and may lead to tendinitis. Treatment may include rest, heat, and corticosteroid injections.

PELLEGRINI-STIEDA SYNDROME: This generally occurs in men and is thought to be caused by repeated trauma causing calcification of the inner ligament of the knee (the mediocollateral ligament). The pain is self-limited and improvement usually occurs after a few months.

TENDON RUPTURE: Rupture of the quadriceps (the major thigh anterior muscle group) and inferior patellar tendons may occur due to acute or repetitive trauma, sometimes from sports activities. Tendon ruptures may be seen with an increased incidence in patients with chronic kidney failure, rheumatoid arthritis, hyperparathyroidism, gout and systemic lupus erythematosus treated with steroids. Initially the patient experiences a sharp pain and cannot extend the leg. Treatment is with surgical repair.

NO NAME, NO FAME BURSITIS: An unnamed bursa (Latin for sac) is located in the knee between the superficial and deep portions of the mediocollateral ligament. Pain is especially apparent when the knee is flexed to a right angle (90°). Local corticosteroid injections into the bursa usually alleviate the symptoms.

Just as "all that glitters is not gold", so is it also true that "all pain in the region of the knee is not due to arthritis".

Norman S. Koval, M.D.

RHEUMINATIONS

SPECIAL CLOTHING BECOMING THE FASHION

There's some good fashion news for people with arthritis, wheelchair users, and others with physically challenging health conditions. Satin pants, bolero jackets, tailored trousers and leather bomber jackets, to mention a few.

The clothes in the Avenues catalog are cut to accommodate a seated figure. Pants are designed with extra seat room, less lap area, stay-put elastic waistbands, longer inseams that won't ride up and accessible pockets. Jackets and coats are cut shorter to fit correctly and have action-back pleats. Many of the skirts have full side openings.

JC Penney also is opening new doors by catering to those with arthritis and rheumatism; its catalog for women - Easy Dressing Fashions - is in its third season.
JC Penney uses a new Velcro Wavelok for fastening everything. For example, buttons are used solely for decoration. Wavelok is used behind every button on a blouse, jacket, dress or skirt. It's also used for belts, cuffs and waistbands.

To receive an Avenues catalog, call (800) 848-2837, and to receive an Easy Dressing Fashions catalog, call (800) 222-6161. We hope to have one of each available in our office soon.

CLINICAL RESEARCH STUDIES

We feel privileged at Arthritis and Rheumatism Associates to be able to offer our patients the opportunity to participate in clinical trials of new medications for arthritis. Two of the medications we have previously studied, Ansaid and Voltaren, have been released by the FDA and are now available to the general public. During the past ten years, we have worked with numerous pharmaceutical companies including Upjohn, Pfizer, Wyeth-Ayerst, Ciba-Geigy, and Syntex to help evaluate new arthritis medications. At present we are studying medicines for Rheumatoid Arthritis and Osteoarthritis, and are still actively enrolling patients with these diagnoses who qualify for study.

Patients who have participated in drug trials have enjoyed the experience of learning how new medications "make it to the market-place". There is no cost to the patient to participate in these trials. If you think you might be interested, and have a diagnosis of either Osteoarthritis of the *hip or knee*, or of Rheumatoid Arthritis, we invite you to check with your physician for details.

WE NOW "PARTICIPATE" WITH MEDICARE

Perhaps the biggest change of the New Year for Arthritis and Rheumatism Associates is that we are now participating physicians with the Medicare program. This means that we will be accepting assignment on all claims.

Due to the significant volume of Medicare patients in our practice, we will now ask all of our

Medicare patients (except those with BCBSNCA as their secondary insurer) to file their own secondary insurance. We will ask for payment of the co-pay at the time of your visit and your secondary insurance will re-imburse you directly. We would also like to remind you that your $100.00 annual deductible is payable for the new calendar year.

We hope you find our participating status "good news" and that it starts your New Year on a happy note!

QUESTIONS & ANSWERS

Q.
MY JOINTS HURT EVERY TIME IT IS ABOUT TO RAIN. IS THERE ANY TRUTH TO THE IDEA THAT THE WEATHER AFFECTS ARTHRITIS?

A.
Yes, most patients with arthritis will tell you that their joints become more achy with changes in weather, usually from fair to inclement. While this observation is well documented, the scientific basis for this is not. The most popular current theory holds that a fall in atmospheric pressure (usually signifying the arrival of foul weather) is mirrored by a rise in pressure within the closed space which forms the joint. This increase in pressure can especially irritate an already inflamed joint, and be interpreted by the patient as an increase in arthritis pain.

Q.
CAN OVER-THE-COUNTER PREPARATIONS SUCH AS ASPIRIN BE USEFUL FOR ARTHRITIS?

A.
Non prescription oral medications for arthritis such as aspirin, ibuprofen, and acetaminophen can be very useful for minor aches and pains in the joints and elsewhere when used at the manufacturers recommended dosage. These dosages are also generally helpful in the treatment of Degenerative or Osteoarthritis, but are not adequate for the treatment of inflammatory types of arthritis such as Rheumatoid Arthritis or Gout. Acetaminophen has no anti-inflammatory properties at all. Aspirin in low doses can actually make Gout worse. However, aspirin and ibuprofen in higher doses can be just as effective as prescription medications in the treatment of certain types of inflammatory arthritis. It should be remembered though, that at higher doses, these medications become significantly more toxic, and must be given only under the guidance of a physician.

Q.
I HAVE HAD MY KNEE INJECTED WITH CORTISONE. IT HELPED BUT I AM WORRIED ABOUT HOW SAFE THIS IS. HOW OFTEN CAN THIS BE DONE?

A.
Joint injections with cortisone are very effective and quite safe when done with a modified sterile technique. The biggest risk is infection, occurring once in approximately 20-50 thousand cases. The cortisone stays mostly in the joint where it controls inflammation locally, but some "spills" out into the blood stream. Effects from this may include a flushing of the face that lasts up to a day and, in diabetic patients, a short-lived rise in the blood sugar.

It is generally recommended that a given joint not be injected more often than 4 times a year.

"THE MANY FACES OF SJOGRENS SYNDROME"

Out of the more than 100 types of arthritis recognized by rheumatologists, Sjogrens Syndrome (SS) is probably one of the least well understood and most underdiagnosed. Sjogrens syndrome was first called Mikulicz's syndrome in 1982 after the Polish surgeon who first reported it. It was not until 1932 when Swedish ophthalmologist, Henrick Sjogren, noted the association of dry eyes (keratoconjunctivitis sicca) and dry mouth (xerostomia) in rheumatoid arthritis patients that the classic "triad" (dry eyes, dry mouth, arthritis) of SS was recognized. American physicians Morgan & Castleman further refined the definition of SS in 1953. We now recognize SS as an important form of arthritis affecting approximately 400,000 people in the US alone.

SS is an auto-immune disorder that affects the exocrine glands - salivary, tear, and other moisture secreting glands. In SS and other auto-immune disorders, the body's defense or immune system mistakes some of the patient's own tissues for foreign invaders and attacks these tissues, sometimes destroying them. The moisture secreting glands of the eyes and mouth are the primary targets. Dry eyes and dry mouth may therefore result.

SS is also a systemic disease that potentially affects many other organs of the body including joints, skin, lungs, kidney, nervous system, gastrointestinal tract, lymph glands, thyroid and blood vessels. Involvement of these organ systems may cause other symptoms seen in SS including: arthritis, dry skin, cough or shortness of breath, urinary problems, numbness, abdominal pain, swelling of glands, fatigue, and skin rash. Patients may feel systemically ill with fever, loss of endurance, and "flu-like" symptoms.

The cause of SS is unknown, but one-half of SS patients have an established association with other connective tissue disorders such as rheumatoid arthritis or lupus. Fifteen percent of all rheumatoid arthritis patients have SS. The other half of SS patients have no recognizable underlying connective tissue disorder and are considered to have primary SS. While research has shown an association with genetic characteristics, HLA-D3 and D4, prediction of clinical disease in adults and children is unreliable. Rather, it is felt that the presence of certain genetic characteristics may make one more susceptible to develop SS, but the conditions required to develop actual disease are unknown.

Diagnosis of SS is based on the patient's symptoms (what he/she complains of), signs (what the doctor finds on examination), and laboratory testing. Decreased tear production can be documented by a Schirmer test. Abnormal antibodies can be detected in the blood and lip biopsy can demonstrate changes in the small salivary glands of the mouth.

While SS is not curable, it can be well managed. Eyedrops and oral saliva replacement solutions can be effective in replacing lost moisture in the eyes and mouth. In more severe cases, eye moisture chambers can be customized to keep the eyes moist at night. Salivary stimulants may help increase saliva flow but often patients need not do more than drink frequent sips of water throughout the day. Nasal passage moisturizers and lubricants are also helpful. Women with severe vaginal dryness benefit from vaginal lubricants.

The arthritis of SS is treated much like rheumatoid arthritis with the use of NSAIDS. Rarely are steroids necessary. Lung and kidney complications are often treated with consultation from pulmonary and renal specialists.

Patient's have some of the best ideas for treating the dry mouth and eyes of SS. The Sjogrens Syndrome Foundation and the newsletter, *"The Moisture Seekers"*, offer assistance and support to SS patients. As with all rheumatic disease patients - those who read and learn will help themselves the most.

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